EXHIBIT 76

PRACTITONER QUESTIONNAIRE

Servicing Distributions Center(s) _____

Name / Phone Number of BDM or Account Manager: _____

This questionnaire is to be completed by the Owner and Business Development Person during an on-site visit

1. **Practitioner Name:** _____
   a. **ABC Account number** _____
   b. **Practice's dba (doing business as), if any** _____
   c. **Has the Practitioner ever operated under a different name?**
      i. **Yes____ No____ If yes, provide the Name:**
      _____

2. **If existing ABC customer:**
   a. **Has been customer of ABC: Years_____ Months_____**
   b. **Customer's current ratio of CS to Non-CS invoice lines % _____**
   c. **Customer's total monthly dollar purchase volume w/ABC _____**
   d. **Is customer a Primary_____ or Secondary Account_____ with ABC?**
   e. **Does customer have Prime Vendor agreement? Yes___ No___**
   f. **Is customer part of a Buying Group?**
   Yes____ No____ If yes, provide the Name: _____

3. **Practice Address:** _____
   a. **City**_____
   b. **State**_____
   c. **Zip**_____

4. **Practice Phone Number:** _____ **Fax Number:** _____

5. **Practice Email Address:** _____

6. **Name of individual responsible for controlled substances (ordering, recordkeeping, handling, security, etc.** _____

7. **Is this Practice affiliated with any other Practice locations?**
   Yes____ No____ If yes, provide the following:
   Name: _____
   Address: _____
   Phone Number: _____**Fax Number:**_____

   Note: If there are additional affiliates please attach an additional sheet with the information

8. **Does Practitioner(s) have hospital privileges?**
   Yes____ No____ If yes, list hospitals:
   _____
   _____
   _____

9. Ownership type: Check one
   a. Sole Proprietor ____ Corporation_____ Partnership____
      i. Other _____ (describe)
   b. If corporation, state of incorporation_____
   c. If corporation, Chief Executive Officer _____

10. Owner(s) name: _____

    a. Owner's dba (doing business as), if any _____

11. Owner Business Address: _____

12. Owner Phone Number: _____ Fax Number: _____

13. Owner Email Address: _____

14. Number of years owner has operated Practice _____

15. Is the Owner a licensed physician?
    Yes____ No____

16. Physician's DEA registration #: _____

17. State Medical license #_____

18. State Controlled Substance license # if required _____

19. Has any Practitioner at the practice ever had a DEA registration or State license suspended or revoked?
    Yes____ No____ If yes, give details (when, why, etc.)
    _____
    _____

20. Has the Owner ever had a DEA registration or State license suspended or revoked?
    Yes____ No____ If so, give details (when, why, etc.)
    _____
    _____

21. Is the Practitioner a member of any professional associations (AMA, etc.)
    Yes____ No____ If yes, provide name(s) _____

22. Does the Practitioner have any other board certifications? (Pain Management, Bariatrics, etc.)
    Yes____ No____ If yes, give specifics _____

23. Does the Practitioner have any other licensure/registration? (buprenorphics, CSAT etc…)
    Yes____ No____ If so, provide copies.

24. Check the following manners of receiving business and provide what percentage of the total business it comprises:

Walk-In	Yes____	No____	_____%
Phone	Yes____	No____	_____%
Fax	Yes____	No____	_____%
Internet/Mail Order	Yes____	No____	_____%

25. Are prescriptions written by physicians located in the state in which the patient resides?
Yes____ No____

26. How many controlled substance prescriptions are written daily_____;
monthly_____?

27. How many controlled substance dosage units are dispensed daily_____;
monthly_____?

28. Does the practitioner refer patients to specific pharmacies?
Yes_____ No_____ If Yes, provide names of Pharmacy(s):
_____
_____

29. Check the following types of products and provide the approximate percentage of products you expect to purchase from AmerisourceBergen?

HBA	Yes____	No____	_____% of total purchases
OTC	Yes____	No____	_____% of total purchases
Non-Controlled Rx	Yes____	No____	_____% of total purchases
Controlled Substances	Yes____	No____	_____% of total purchases
Listed Chemicals	Yes____	No____	_____% of total purchases

30. Check the following types of products and provide the approximate percentage of products you expect to purchase from other suppliers

HBA	Yes____	No____	_____% of total purchases
OTC	Yes____	No____	_____% of total purchases
Non-Controlled Rx	Yes____	No____	_____% of total purchases
Controlled Substances	Yes____	No____	_____% of total purchases
Listed Chemicals	Yes____	No____	_____% of total purchases

31. Please provide a list of names of all suppliers you intend to continue to use
_____
_____

32. Please provide a list of names of all suppliers you have used within the last 24 months_____
_____

33. Does the practice expect to order more than 3,000 dosage units (tabs/caps) of Controlled Substances a month? Yes_____No ____ If yes, list controlled substances and quantity? _____
_____
_____
_____

34. Does the Practice have a web site?
Yes____ No____ If yes, provide web address(es):
_____

Note: If no, you are required to notify us immediately upon establishing a web site.

35. **Is the Practice affiliated with a web site?**
Yes____ No____ If yes, provide web address(es):
_____

Note: If no, you are required to notify us immediately upon affiliating with a web site.

36. **Check the following types of payments the Practice receives for products and provide the approximate percentage of total payments:**

Private Insurance	**Yes____**	**No____**	**_____% of revenue**
Medicare/Medicaid	**Yes____**	**No____**	**_____% of revenue**
Cash	**Yes____**	**No____**	**_____% of revenue**
Other	**Yes____**	**No____**	**_____% of revenue**

If other, provide details _____

37. **Attach and date photographs of Practice building (2 of inside, including counter area & 2 of outside-front and back of Practice).**

OTHER COMMENTS/OBSERVATIONS:

I, as the Owner or [authorized representative or officer of the Owner], declare that I have completed this Practitioner Questionnaire and to the best of my knowledge and belief the information provided is true, correct and complete.

WITNESS:

AMERISOURCEBERGEN DRUG CORPORATION

_____
AmerisourceBergen Associate Signature

_____
Full Name (Print)

_____
Title

_____
Cell Phone Number

OWNER:

_____
Name of Entity/Person

By: _____

_____
Name:

_____
Title:

_____
Date:

